For cannabis intoxication, without perceptual disturbances: If a mild cannabis use disorder is comorbid, the ICD-10-CM code is **F12.120,** and if a moderate or severe cannabis use disorder is comorbid, the ICD-10-CM code is **F12.220.** If there is no comorbid cannabis use disorder, then the ICD-10-CM code is **F12.920.**

For cannabis intoxication, with perceptual disturbances: If a mild cannabis use disorder is comorbid, the ICD-10-CM code is **F12.122,** and if a moderate or severe cannabis use disorder is comorbid, the ICD-10-CM code is **F12.222.** If there is no comorbid cannabis use disorder, then the ICD-10-CM code is **F12.922.**

Specifiers

When hallucinations occur in the absence of intact reality testing, a diagnosis of substance/medication-induced psychotic disorder should be considered.

Diagnostic Features

The essential feature of cannabis intoxication is the presence of clinically significant problematic behavioral or psychological changes that develop during, or shortly after, cannabis use (Criterion B). Intoxication typically begins with a "high" feeling followed by symptoms that include euphoria with inappropriate laughter and grandiosity, sedation, lethargy, impairment in short-term memory, difficulty carrying out complex mental processes, impaired judgment, distorted sensory perceptions, impaired motor performance, and the sensation that time is passing slowly. Occasionally, anxiety (which can be severe), dysphoria, or social withdrawal occurs. These psychoactive effects are accompanied by two or more of the following signs, developing within 2 hours of cannabis use: conjunctival injection, increased appetite, dry mouth, and tachycardia (Criterion C).

Intoxication develops within minutes if plant cannabis is smoked, and may take a few hours to develop when the cannabis is ingested orally. The effects usually last 3–4 hours, with duration longer when the substance is ingested orally. The magnitude of the behavioral and physiological changes depends on the dose, the method of administration, and the characteristics of the individual using the substance, such as rate of absorption, tolerance, and sensitivity to the effects of the substance. Because most cannabinoids, including delta-9-tetrahydrocannabinol (delta-9-THC), are fat soluble, the effects of cannabis or hashish may occasionally persist or reoccur for 12–24 hours because of the slow release of psychoactive substances from fatty tissue or to enterohepatic circulation.

Synthetic cannabinoids (e.g., Spice), whose use has become more common in recent years, also produce rapid effects, including euphoria, talkativeness, feelings of joy and laughter, and relaxation. In terms of psychoactive effects, low doses of synthetic cannabinoids and other cannabis products are similar. At higher doses of synthetic cannabinoids, delusional and hallucinatory symptoms are more likely to occur.

Prevalence

The prevalence of episodes of cannabis intoxication in the general population is unknown. However, it is probable that most individuals using cannabis would at some time experience symptoms that meet criteria for cannabis intoxication. Given this, the prevalence of individuals using cannabis and the prevalence of individuals experiencing cannabis intoxication are likely similar.

Functional Consequences of Cannabis Intoxication

Impairment from cannabis intoxication may have serious consequences, including dysfunction at work or school, social indiscretions, failure to fulfill role obligations, traffic accidents, and having unprotected sex. In rare cases, cannabis intoxication may precipitate a psychosis that may vary in duration.

Differential Diagnosis

Note that if the clinical presentation includes hallucinations in the absence of intact reality testing, a diagnosis of substance/medication-induced psychotic disorder should be considered.

Other substance intoxication. Cannabis intoxication may resemble intoxication with other types of substances. However, in contrast to cannabis intoxication, alcohol intoxication and sedative, hypnotic, or anxiolytic intoxication frequently decrease appetite, increase aggressive behavior, and produce nystagmus or ataxia. Hallucinogens in low doses may cause a clinical picture that resembles cannabis intoxication. Phencyclidine, like cannabis, can be smoked and also causes perceptual changes, but phencyclidine intoxication is much more likely to cause ataxia and aggressive behavior.

Cannabis-induced mental disorders. Cannabis intoxication is distinguished from cannabis-induced mental disorders (e.g., cannabis-induced anxiety disorder, with onset during intoxication) because the symptoms (e.g., anxiety) in these latter disorders are in excess of those usually associated with cannabis intoxication, predominate in the clinical presentation, and are severe enough to warrant independent clinical attention.

Comorbidity

Given the typical overlap of cannabis intoxication with cannabis use disorder, see "Comorbidity" under Cannabis Use Disorder for more details about co-occurring conditions that are likely to be encountered.

Cannabis Withdrawal

Diagnostic Criteria

A. Cessation of cannabis use that has been heavy and prolonged (i.e., usually daily or almost daily use over a period of at least a few months).

B. Three (or more) of the following signs and symptoms develop within approximately 1 week after Criterion A:

   1. Irritability, anger, or aggression.
   2. Nervousness or anxiety.
   3. Sleep difficulty (e.g., insomnia, disturbing dreams).
   4. Decreased appetite or weight loss.
   5. Restlessness.
   6. Depressed mood.
   7. At least one of the following physical symptoms causing significant discomfort: abdominal pain, shakiness/tremors, sweating, fever, chills, or headache.

C. The signs or symptoms in Criterion B cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

D. The signs or symptoms are not attributable to another medical condition and are not better explained by another mental disorder, including intoxication or withdrawal from another substance.

Coding note: The ICD-10-CM code depends on whether or not there is a comorbid cannabis use disorder. If a mild cannabis use disorder is comorbid, the ICD-10-CM code is **F12.13**, and if a moderate or severe cannabis use disorder is comorbid, the ICD-10-CM code is **F12.23**. For cannabis withdrawal occurring in the absence of a cannabis use disorder (e.g., in a patient taking cannabis solely under appropriate medical supervision), the ICD-10-CM code is **F12.93**.

Diagnostic Features

The essential feature of cannabis withdrawal is the presence of a characteristic withdrawal syndrome that develops after the cessation of regular cannabis use. Regular users become tolerant to many acute cannabis effects, and cessation of regular use can lead to a cannabis withdrawal syndrome. Common cannabis withdrawal symptoms include irritability, depressed mood, anxiety, restlessness, sleep difficulty, and decreased appetite or weight loss. Cannabis withdrawal can cause significant distress, leading to continued use to relieve the symptoms, difficulty in quitting, and relapse. Unlike withdrawal from other substances (i.e., opioids, alcohol, sedatives), behavioral and emotional symptoms (e.g., nervousness, irritability, sleep difficulty) are often more common than physical symptoms (e.g., shakiness, sweating).

Associated Features

Cannabis withdrawal may be accompanied by observed fatigue, yawning, difficulty concentrating, and rebound periods of increased appetite and hypersomnia that follow initial periods of loss of appetite and insomnia.

Prevalence

Among adult and adolescent cannabis users, prevalence estimates of cannabis withdrawal symptoms vary widely, from 35% to 95%, based on research in the United States and other countries. Some of the variation in rates is likely attributable to assessment methods, and some to differences between samples. Among adult regular cannabis users in the general population, 12% reported signs and symptoms that met criteria for the full syndrome of DSM-5 cannabis withdrawal, with substantial differences in prevalence among non-Latinx Whites (10%), African Americans (15.3%), and Asian Americans, Native Hawaiians, and Pacific Islanders (31%). Among adults and adolescents who are enrolled in treatment or are heavy cannabis users, 50%–95% report cannabis withdrawal. These findings indicate that cannabis withdrawal occurs among a substantial subset of regular cannabis users who try to quit.

Development and Course

Withdrawal onset typically occurs within 24–48 hours after cessation of use. It peaks within 2–5 days and resolves within 1–2 weeks, although sleep disturbance can persist longer. The amount, duration, and frequency of cannabis smoking required to produce cannabis withdrawal are unknown, but more chronic and frequent cannabis use is associated with greater quantity and severity of withdrawal symptoms. Cannabis withdrawal can occur in adults and adolescents. Women may experience more severe cannabis withdrawal symptoms than men.

Risk and Prognostic Factors

Among cannabis users, the propensity to experience cannabis withdrawal is moderately heritable, indicating genetic influences. The prevalence and severity of cannabis withdrawal are greater among heavier cannabis users, particularly those seeking treatment for cannabis use disorder. Withdrawal severity may also be related to the presence and severity of comorbid symptoms of mental disorders.

Functional Consequences of Cannabis Withdrawal

Cannabis users report using cannabis to relieve withdrawal symptoms, making cannabis withdrawal a contributor to the persistence of cannabis use disorder. This makes cannabis withdrawal a current target for medication development. Worse outcomes may be associ-

ated with greater withdrawal. Sleep difficulty has been reported as the withdrawal symptom most often associated with relapse to cannabis use. Cannabis users report having relapsed to cannabis use or initiating use of other drugs (e.g., tranquilizers) to provide relief from cannabis withdrawal symptoms.

Differential Diagnosis

Because many of the symptoms of cannabis withdrawal are also symptoms of other substance withdrawal syndromes or of depressive or bipolar disorders, careful evaluation should focus on ensuring that the symptoms are not better explained by cessation of another substance (e.g., tobacco or alcohol withdrawal), another mental disorder (generalized anxiety disorder, major depressive disorder), or another medical condition. Given the increasingly common belief that cannabis use is harmless, regular cannabis users experiencing cannabis withdrawal may not realize that their withdrawal symptoms are due to the effects of cannabis wearing off, and continue to use cannabis as a form of self-medication.

Comorbidity

Among adult frequent cannabis users, cannabis withdrawal is associated with comorbid depression, anxiety, and antisocial personality disorder. Given the typical overlap of cannabis withdrawal with cannabis use disorder, see "Comorbidity" under Cannabis Use Disorder for more details about co-occurring conditions that are likely to be encountered.

Cannabis-Induced Mental Disorders

The following cannabis-induced mental disorders are described in other chapters of the manual with disorders with which they share phenomenology (see the substance/medication-induced mental disorders in these chapters): cannabis-induced psychotic disorder ("Schizophrenia Spectrum and Other Psychotic Disorders"); cannabis-induced anxiety disorder ("Anxiety Disorders"); and cannabis-induced sleep disorder ("Sleep-Wake Disorders"). For cannabis intoxication delirium and delirium induced by pharmaceutical cannabis receptor agonists taken as prescribed, see the criteria and discussion of delirium in the chapter "Neurocognitive Disorders." These cannabis-induced mental disorders are diagnosed instead of cannabis intoxication or cannabis withdrawal when the symptoms are sufficiently severe to warrant independent clinical attention.

Unspecified Cannabis-Related Disorder

F12.99

This category applies to presentations in which symptoms characteristic of a cannabis-related disorder that cause clinically significant distress or impairment in social, occupational, or other important areas of functioning predominate but do not meet the full criteria for any specific cannabis-related disorder or any of the disorders in the substance-related and addictive disorders diagnostic class.

Hallucinogen-Related Disorders

Phencyclidine Use Disorder
Other Hallucinogen Use Disorder
Phencyclidine Intoxication
Other Hallucinogen Intoxication
Hallucinogen Persisting Perception Disorder
Phencyclidine-Induced Mental Disorders
Hallucinogen-Induced Mental Disorders
Unspecified Phencyclidine-Related Disorder
Unspecified Hallucinogen-Related Disorder

Phencyclidine Use Disorder

Diagnostic Criteria

A. A pattern of phencyclidine (or a pharmacologically similar substance) use leading to clinically significant impairment or distress, as manifested by at least two of the following, occurring within a 12-month period:

1. Phencyclidine is often taken in larger amounts or over a longer period than was intended.
2. There is a persistent desire or unsuccessful efforts to cut down or control phencyclidine use.
3. A great deal of time is spent in activities necessary to obtain phencyclidine, use the phencyclidine, or recover from its effects.
4. Craving, or a strong desire or urge to use phencyclidine.
5. Recurrent phencyclidine use resulting in a failure to fulfill major role obligations at work, school, or home (e.g., repeated absences from work or poor work performance related to phencyclidine use; phencyclidine-related absences, suspensions, or expulsions from school; neglect of children or household).
6. Continued phencyclidine use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the phencyclidine (e.g., arguments with a spouse about consequences of intoxication; physical fights).
7. Important social, occupational, or recreational activities are given up or reduced because of phencyclidine use.
8. Recurrent phencyclidine use in situations in which it is physically hazardous (e.g., driving an automobile or operating a machine when impaired by a phencyclidine).
9. Phencyclidine use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the phencyclidine.
10. Tolerance, as defined by either of the following:
    a. A need for markedly increased amounts of the phencyclidine to achieve intoxication or desired effect.

b. A markedly diminished effect with continued use of the same amount of the phencyclidine.

Note: Withdrawal symptoms and signs are not established for phencyclidines, and so this criterion does not apply. (Withdrawal from phencyclidines has been reported in animals but not documented in human users.)

Specify if:

In early remission: After full criteria for phencyclidine use disorder were previously met, none of the criteria for phencyclidine use disorder have been met for at least 3 months but for less than 12 months (with the exception that Criterion A4, "Craving, or a strong desire or urge to use the phencyclidine," may be met).

In sustained remission: After full criteria for phencyclidine use disorder were previously met, none of the criteria for phencyclidine use disorder have been met at any time during a period of 12 months or longer (with the exception that Criterion A4, "Craving, or a strong desire or urge to use the phencyclidine," may be met).

Specify if:

In a controlled environment: This additional specifier is used if the individual is in an environment where access to phencyclidines is restricted.

Code based on current severity/remission: If a phencyclidine intoxication or another phencyclidine-induced mental disorder is also present, do not use the codes below for phencyclidine use disorder. Instead, the comorbid phencyclidine use disorder is indicated in the 4th character of the phencyclidine-induced disorder code (see the coding note for phencyclidine intoxication or a specific phencyclidine-induced mental disorder). For example, if there is comorbid phencyclidine-induced psychotic disorder, only the phencyclidine-induced psychotic disorder code is given, with the 4th character indicating whether the comorbid phencyclidine use disorder is mild, moderate, or severe: F16.159 for mild phencyclidine use disorder with phencyclidine-induced psychotic disorder or F16.259 for a moderate or severe phencyclidine use disorder with phencyclidine-induced psychotic disorder.

Specify current severity/remission:

F16.10 Mild: Presence of 2–3 symptoms.
F16.11 Mild, In early remission
F16.11 Mild, In sustained remission
F16.20 Moderate: Presence of 4–5 symptoms.
F16.21 Moderate, In early remission
F16.21 Moderate, In sustained remission
F16.20 Severe: Presence of 6 or more symptoms.
F16.21 Severe, In early remission
F16.21 Severe, In sustained remission

Specifiers

"In a controlled environment" applies as a further specifier of remission if the individual is both in remission and in a controlled environment (i.e., in early remission in a controlled environment or in sustained remission in a controlled environment). Examples of these environments are closely supervised and substance-free jails, therapeutic communities, and locked hospital units.

Diagnostic Features

The phencyclidines (or phencyclidine-like substances) include phencyclidine (e.g., PCP, "angel dust") and less potent but similarly acting compounds such as ketamine, cyclohex-

amine, and dizocilpine. These substances were first developed as dissociative anesthetics in the 1950s and became street drugs in the 1960s. They produce feelings of separation from mind and body (hence "dissociative") in low doses, and at high doses, stupor and coma can result. These substances are most commonly smoked or taken orally, but they may also be snorted or injected. Although the primary psychoactive effects of phencyclidine last for a few hours, the total elimination rate of this drug from the body typically extends 8 days or longer. The hallucinogenic effects in vulnerable individuals may last for weeks and may precipitate a persistent psychotic episode resembling schizophrenia. Ketamine has been observed to have utility in the treatment of major depressive disorder. Withdrawal symptoms have not been clearly established in humans, and therefore the withdrawal criterion is not included in the diagnosis of phencyclidine use disorder.

Associated Features

Phencyclidine may be detected in urine for up to 8 days or even longer at very high doses. In addition to laboratory tests to detect its presence, characteristic symptoms resulting from intoxication with phencyclidine or related substances may aid in its diagnosis. Phencyclidine is likely to produce dissociative symptoms, analgesia, nystagmus, risk of hypertension/hypotension and shock, euphoria, visual/auditory hallucinations, derealization, and unusual thought content. Violent behavior can also occur with phencyclidine use, as intoxicated individuals may believe that they are being attacked.

Prevalence

Data on the prevalence of phencyclidine use disorder are not available, but rates appear to be low (based on rates of the overall category of hallucinogen use disorder, which includes phencyclidine, of about 0.1% among individuals age 12 and older in the United States). Furthermore, among U.S. substance use treatment facility admissions, only 0.3% of the admitted individuals endorsed phencyclidine as their primary drug.

Risk and Prognostic Factors

In a general population study in Australia, ketamine users were more likely to be men and to have consumed more than 11 standard drinks per day.

Sex- and Gender-Related Diagnostic Issues

The gender ratio for phencyclidine use disorder is not known, but among U.S. substance use treatment facility admissions endorsing phencyclidine as the primary drug, 62% were men.

Diagnostic Markers

Laboratory testing may be useful, as phencyclidine is present in the urine in intoxicated individuals up to 8 days after ingestion. The individual's history along with certain physical signs (e.g., nystagmus, analgesia, prominent hypertension) may aid in distinguishing the phencyclidine clinical picture from that of other hallucinogens.

Functional Consequences of Phencyclidine Use Disorder

In individuals with phencyclidine use disorder, there may be physical evidence of injuries from accidents, fights, and falls. Chronic use of phencyclidine can lead to acute and persistent cognitive impairment; urinary tract and intestinal symptoms; abdominal pain, chest pain, palpitations, and tachycardia; respiratory depression; sleep disorders; and depression.

Differential Diagnosis

Other substance use disorders. Distinguishing the effects of phencyclidine from those of other substances may be important, because phencyclidine can be an additive to other substances (e.g., cannabis, cocaine).

Phencyclidine intoxication and phencyclidine-induced mental disorders. Phencyclidine use disorder is differentiated from phencyclidine intoxication and phencyclidine-induced mental disorders (e.g., phencyclidine-induced psychotic disorder) in that phencyclidine use disorder describes a problematic pattern of phencyclidine use that involves impaired control over phencyclidine use, social impairment attributable to phencyclidine use, risky phencyclidine use (e.g., driving while intoxicated), and pharmacological symptoms (the development of tolerance), whereas phencyclidine intoxication and phencyclidine-induced mental disorders describe psychiatric syndromes that occur in the context of heavy use. Phencyclidine intoxication and phencyclidine-induced mental disorders occur frequently in individuals with phencyclidine use disorder. In such cases, a diagnosis of phencyclidine intoxication or a phencyclidine-induced mental disorder should be given in addition to a diagnosis of phencyclidine use disorder, the presence of which is indicated in the diagnostic code.

Independent mental disorders. Some of the effects of phencyclidine use may resemble symptoms of independent mental disorders, such as psychosis (schizophrenia); low mood (major depressive disorder); and violent, aggressive behaviors (conduct disorder, antisocial personality disorder). Discerning whether these behaviors occurred before the intake of the drug is important in the differentiation of acute drug effects from a preexisting mental disorder.

Comorbidity

Conduct disorder in adolescents and antisocial personality disorder may be associated with phencyclidine use. Other substance use disorders, especially alcohol, cocaine, and amphetamine use disorders, are common among those with phencyclidine use disorder.

Other Hallucinogen Use Disorder

Diagnostic Criteria

A. A problematic pattern of hallucinogen (other than phencyclidine) use leading to clinically significant impairment or distress, as manifested by at least two of the following, occurring within a 12-month period:

1. The hallucinogen is often taken in larger amounts or over a longer period than was intended.
2. There is a persistent desire or unsuccessful efforts to cut down or control hallucinogen use.
3. A great deal of time is spent in activities necessary to obtain the hallucinogen, use the hallucinogen, or recover from its effects.
4. Craving, or a strong desire or urge to use the hallucinogen.
5. Recurrent hallucinogen use resulting in a failure to fulfill major role obligations at work, school, or home (e.g., repeated absences from work or poor work performance related to hallucinogen use; hallucinogen-related absences, suspensions, or expulsions from school; neglect of children or household).
6. Continued hallucinogen use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the hallucinogen (e.g., arguments with a spouse about consequences of intoxication; physical fights).

7. Important social, occupational, or recreational activities are given up or reduced because of hallucinogen use.
8. Recurrent hallucinogen use in situations in which it is physically hazardous (e.g., driving an automobile or operating a machine when impaired by the hallucinogen).
9. Hallucinogen use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the hallucinogen.
10. Tolerance, as defined by either of the following:
    a. A need for markedly increased amounts of the hallucinogen to achieve intoxication or desired effect.
    b. A markedly diminished effect with continued use of the same amount of the hallucinogen.

Note: Withdrawal symptoms and signs are not established for hallucinogens, and so this criterion does not apply.

Specify **the particular hallucinogen.**

Specify if:

In early remission: After full criteria for other hallucinogen use disorder were previously met, none of the criteria for other hallucinogen use disorder have been met for at least 3 months but for less than 12 months (with the exception that Criterion A4, "Craving, or a strong desire or urge to use the hallucinogen," may be met).

In sustained remission: After full criteria for other hallucinogen use disorder were previously met, none of the criteria for other hallucinogen use disorder have been met at any time during a period of 12 months or longer (with the exception that Criterion A4, "Craving, or a strong desire or urge to use the hallucinogen," may be met).

Specify if:

In a controlled environment: This additional specifier is used if the individual is in an environment where access to hallucinogens is restricted.

Code based on current severity/remission: If a hallucinogen intoxication or another hallucinogen-induced mental disorder is also present, do not use the codes below for hallucinogen use disorder. Instead, the comorbid hallucinogen use disorder is indicated in the 4th character of the hallucinogen-induced disorder code (see the coding note for hallucinogen intoxication or specific hallucinogen-induced mental disorder). For example, if there is comorbid hallucinogen-induced psychotic disorder and hallucinogen use disorder, only the hallucinogen-induced psychotic disorder code is given, with the 4th character indicating whether the comorbid hallucinogen use disorder is mild, moderate, or severe: F16.159 for mild hallucinogen use disorder with hallucinogen-induced psychotic disorder or F16.259 for a moderate or severe hallucinogen use disorder with hallucinogen-induced psychotic disorder.

Specify current severity/remission:

F16.10 Mild: Presence of 2–3 symptoms.
F16.11 Mild, In early remission
F16.11 Mild, In sustained remission
F16.20 Moderate: Presence of 4–5 symptoms.
F16.21 Moderate, In early remission
F16.21 Moderate, In sustained remission
F16.20 Severe: Presence of 6 or more symptoms.
F16.21 Severe, In early remission
F16.21 Severe, In sustained remission

Specifiers

"In a controlled environment" applies as a further specifier of remission if the individual is both in remission and in a controlled environment (i.e., in early remission in a controlled environment or in sustained remission in a controlled environment). Examples of these environments are closely supervised and substance-free jails, therapeutic communities, and locked hospital units.

Diagnostic Features

Hallucinogens comprise a diverse group of substances that despite having different chemical structures and possibly involving different molecular mechanisms, produce similar alterations of perception, mood, and cognition in users. Hallucinogens included are phenylalkylamines (e.g., mescaline, DOM [2,5-dimethoxy-4-methylamphetamine], and MDMA [3,4-methylenedioxymethamphetamine; also called "ecstasy" or "molly"]); the indoleamines, including psilocybin (and its metabolite psilocin, the compound primarily responsible for the psychedelic effects of hallucinogenic mushrooms) and dimethyltryptamine (DMT); and the ergolines, such as LSD (lysergic acid diethylamide) and morning glory seeds. In addition, miscellaneous other ethnobotanical compounds are classified as hallucinogens, of which *Salvia divinorum* and jimsonweed are two examples. Excluded from the hallucinogen group are cannabis and its active compound, delta-9-tetrahydrocannabinol (THC) (see the section "Cannabis-Related Disorders"). These substances can have hallucinogenic effects but are diagnosed separately because of significant differences in their psychological and behavioral effects.

Hallucinogens are usually taken orally, although some forms are smoked (e.g., DMT, salvia) or (rarely) taken intranasally or by injection (e.g., ecstasy). Duration of effects varies across types of hallucinogens. Some of these substances (i.e., LSD, MDMA) have a long half-life and extended duration such that users may spend hours to days using and/or recovering from the effects of these drugs. However, other hallucinogenic drugs (e.g., DMT, salvia) are short acting. Tolerance to hallucinogens develops with repeated use and has been reported to have both autonomic and psychological effects.

MDMA/ecstasy as a hallucinogen may have distinctive effects attributable to both its hallucinogenic and its stimulant properties. Ecstasy users have a higher risk of developing a hallucinogen use disorder than those using other hallucinogens. Among both adolescent and adult ecstasy users and users of other hallucinogens, the most frequently reported hallucinogen use disorder criteria are tolerance, hazardous use, use despite emotional or health problems, giving up activities in favor of use, and spending a lot of time obtaining, using, or recovering from the effects of use. As found for other substances, diagnostic criteria for other hallucinogen use disorder are arrayed along a single continuum of severity.

Given that a clinically significant withdrawal syndrome has not been consistently documented in humans, the diagnosis of hallucinogen withdrawal syndrome is not included in this manual and therefore is not part of the hallucinogen use disorder diagnostic criteria. However, there may be evidence of withdrawal from MDMA, with endorsement of any two or more withdrawal symptoms (e.g., malaise, appetite disturbance, mood changes [anxious, depressed, irritable], poor concentration, sleep disruption) or withdrawal avoidance observed in more than half of individuals in diverse samples of ecstasy users in the United States and internationally.

Associated Features

The characteristic symptom features of use of some hallucinogens can aid in diagnosis if urine or blood toxicology results are not available. For example, individuals who use LSD tend to experience visual hallucinations that can be frightening.

Prevalence

Other hallucinogen use disorder is rare. In the U.S. general population, about 0.1% of individuals age 12 or older endorsed the symptoms of past 12-month hallucinogen use disorder in 2018. The rate was 0.2% among those ages 12–17, 0.4% among those ages 18–25,